

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

v

File No. 122468-001-SF

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 7th__ day of December 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On July 21, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation. The request was filed under Public Act No. 495 of 2006, MCL 550.1951 *et seq.* Act 495 authorizes the Commissioner to conduct external reviews for state and local government employees who receive health care benefits in a self-funded plan. Under Act 495, the reviews are conducted in the same manner as reviews conducted under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives health care benefits as an eligible dependent under her husband's group coverage through the State of Michigan, a self-funded group. Blue Cross Blue Shield of Michigan (BCBSM) administers the benefit plan. Petitioner's benefits are defined in the *State of Michigan Employees' State Health Plan Benefit Guide*. The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on August 3, 2011.

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On December 14, 2010, the Petitioner, a 56 year-old woman, experienced severe abdominal pain while on vacation in Florida. The Petitioner went to the emergency department of XXXXX. Petitioner notified the staff, upon her arrival, that her insurance coverage required that she be treated by a BCBS-participating provider.

Petitioner was diagnosed with a bowel obstruction which required surgery. On December 16, 2010, surgery was performed by Dr. XXXXX. Dr. XXXXX is not a participating provider with BCBS.

The total charges and BCBSM payments for Petitioner's care are as follows:

Procedure	Charge	BCBSM Payment	Patient Balance
Initial Hospital Care	\$370.00	\$218.46	\$151.54
Exploration of Abdomen	\$2,900.00	\$869.76	\$2,030.24
Freeing of Adhesions	\$5,500.00	\$1,239.43	\$4,260.57
Total	\$8,770.00	\$2,327.65	\$6,442.35

BCBSM paid its approved amount for each of the Petitioner's services and Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on June 20, 2011, and issued a final adverse determination dated June 23, 2011.

III. ISSUE

Is BCBSM required to pay an additional amount for the care Petitioner received from Dr. XXXXX on December 14, 2010 and December 16, 2010?

IV. ANALYSIS

Petitioner's Argument

Petitioner argues that all of Dr. XXXXX's charges should be paid because his services were provided on an emergency basis, and Petitioner twice requested the services of a participating provider. In a letter dated May 20, 2011, Petitioner states:

As I went to and was admitted to this hospital because of an emergency, I had no control over the choice of Surgeon at the time of service. As I was being admitted, I stated at least twice that I must have a BC/BS PPO provider. I was admitted 12/14/2010 and was in pain and on pain medication. After test results I had

surgery 12/16/2010. I was on vacation and my family could not be with me to think to interrogate each and every staff member up to the time of my 12/16/2010 surgery to be sure that each staff member was a participating BC/BS PPO.

I feel and need to have these charges paid in full to Dr. XXXXX (XXXXX) as this was an emergency situation of which I had NO control over at the time. I was alone and on pain medications and just did not think that I would have to question each and every staff to be sure they were qualified to be able to provide my care and that I would be covered completely because I had stated that I MUST have participating BC/BS PPOs upon my arrival being admitted.

BCBSM's Argument

BCBSM states that it paid the full approved amount for the emergency treatment the Petitioner received.

In its final adverse determination dated June 23, 2011, BCBSM wrote:

You are covered by the State of Michigan health care plan. Its benefit guide explains on Page 41 and 43 that you are responsible for the difference between BCBSM's approve[d] amount and the provider's charge when services are rendered by non-participating providers.

As you know, we previously waived the out-of-network cost sharing requirements in this case. However, because Dr. XXXXX is non-participating with the local Blues Plan, you can be billed for the balance (\$6,442.35).

* * *

I realize that you feel that payment at charge should be approved due to the urgent need for the services. As explained, we are bound by the provisions of coverage, and coverage limitations apply.

Commissioner's Review

Under the Petitioner's health care plan, enrollees incur the least out-of-pocket cost if they receive services from providers who participate with BCBSM. The *Benefit Guide* (p. 41) describes the coverage for surgical services from nonparticipating providers. That provision indicates that the covered individual pays the "annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge."

While the Commissioner can understand why the Petitioner feels aggrieved, particularly because she specifically requested a participating Provider for her care, under the Patient's Right to Independent Review Act, the Commissioner's role is limited to determining whether BCBSM properly administered health care benefits under the terms and conditions of the applicable

insurance certificate and relevant state law. There is nothing in the certificate that requires BCBSM to pay more than its approved amount, even in an emergency or even if there are no participating providers available.

The Commissioner finds BCBSM correctly processed the claims for Dr. XXXXX's treatment under the terms and conditions of the certificate.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of June 23, 2011, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's treatment of December 14, 2010 and December 16, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, P.O. Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner